



**THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROFESSIONS LICENSURE
239 CAUSEWAY STREET, SUITE 200
BOSTON, MA 02114
800-414-0168
617-973-0800**

www.mass.gov/dph/boards

BOARD OF REGISTRATION OF PERFUSIONISTS

**Provisional License Application
Instructions and Checklist**

Carefully read the following instructions for completing the Provisional License Application. Complete applications must include the following documents:

_____ Completed application form with notary signature.

_____ Official transcripts in signed sealed envelopes for all undergraduate programs/degrees, perfusion program/degree and any other post-secondary programs/degrees. **Transcripts must be complete and indicate the degree and date conferred.** Transcripts may be sent directly to the Board by the institutions. Transcripts pending completion may be accompanied by a certified letter from the Registrar's Office verifying the completion of all requirements for a degree.

_____ Verification of other licensure status, in signed sealed envelopes, from any state or jurisdiction in which you now or have previously held a professional license. Verifications may be sent directly to the Board by the state or other jurisdictions.

_____ Check or money order payable to the Commonwealth of Massachusetts for \$151.00. Cash or foreign currency is not accepted.

_____ Retain a copy of the completed application for a Provisional License for your records.

For further information, please contact the Board office at 617-973-0806.



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BOARD OF REGISTRATION OF PERFUSIONISTS
ALL QUESTIONS MUST BE COMPLETED
Provisional License - \$151.00

1. Applicant Name: _____
(Last) (First) (Middle)
a. Maiden Name/Other Name (if applicable): _____
(Last) (First) (Middle)
2. Address: _____
(No.) (Street) (Apt.#)

(City/Town) (State) (Zip Code)
3. Most Recent Previous Address: _____
(No.) (Street) (Apt.#)

(City/Town) (State) (Zip Code)
4. Telephone Number(s) Day: _____ Evening: _____
5. Date of Birth: ____/____/____ 6. Place of Birth: _____
(mm/dd/yyyy)
7. Gender: M F 8. Height: _____ 9. Weight: _____ 10. Eye Color: _____
(Circle One)
11. Social Security Number (Disclosure is mandatory): _____ - _____ - _____
Pursuant to G.L. c. 62C, s. 47A, the Division of Health Professions Licensure is required to obtain your social security number and forward it to the Department of Revenue. The Department of Revenue will use your social security number to ascertain whether you are in compliance with the tax and child support laws of the Commonwealth
12. Mother's Maiden Name: _____
13. I certify, under the pains and penalty of perjury, that I have taken, or that I am registered for the next available administration of the ABCP certifying examination.

FOR BOARD USE ONLY

Cash Number: _____

Provisional License Number: _____

Scheduled date of ABCP exam ____/____/____
(mm/yyyy)

Arrange for ABCP to send directly to the Board official documentation of certification or verification of registration for the next examination.

14. Education

Perfusion Program Name/Location: _____

Degree awarded: _____ Date of Graduation: ____/____/____
(mm/yyyy)

Submit official transcript in signed sealed envelope. Transcripts may be mailed directly to the board. Transcripts must be complete and indicate a degree and award date.

Bachelor's Degree School Name/Location: _____

Degree: _____ Date Awarded: ____/____/____
(mm/yyyy)

Submit official transcript in signed sealed envelope. Transcripts may be mailed directly to the board.

Other post-secondary institution(s):

Name: _____

Degree: _____ Date Awarded: ____/____/____
(mm/yyyy)

15. List all professional licenses or certifications held in any other states or jurisdictions.

Submit a certificate of standing from each state or jurisdiction in a signed sealed envelope. Certifications may be mailed directly to the Board.

Lic. No.	Profession	Issuing Jurisdiction
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you answer YES to any of the following questions attach a separate sheet explaining each one.

16. Have you ever been a defendant in a Medical Malpractice claim?

Yes _____ No _____

Include claim number, date(s) and current status of claim with your explanation.

17. Have you ever applied for and been denied a professional license in the United States or any country or foreign jurisdiction?

Yes _____ No _____

18. Has any disciplinary action been taken against you by any licensing or certification board located in the United States or any country or foreign jurisdiction?

Yes _____ No _____

19. Are you the subject of pending disciplinary actions by a licensing or certification board located in the United States or any country or foreign jurisdiction?

Yes _____ No _____

20. Have you voluntarily surrendered any professional license to a licensing or certification board in the United States or any country or foreign jurisdiction?
Yes_____ No_____
21. Have you been arrested, charged, arraigned, indicted, prosecuted, convicted or been the subject of any criminal investigation or any court proceeding in relation to any criminal violation? Do not report minor traffic violations for which a fine of \$100 or less was imposed.
Yes _____ No_____

AFFIDAVIT

I certify, under the pains and penalties of perjury, that the information I have provided pursuant to this application for licensure is truthful and accurate. I understand that the failure to provide accurate information may be grounds for the Massachusetts Board of Registration of Perfusionists to suspend or revoke a license issued to me in accordance with Massachusetts Law. To the best of my knowledge and belief, I have filed all state tax returns and paid all state taxes required by law. I further attest that, pursuant to MGL c.119, s.51A, I will fulfill my obligations to report abuse and neglect of children; that I will otherwise conform to the ethical standards of the medical profession in Massachusetts and all rules and regulations of the Board; and that I have read and understand this affidavit.

I understand that the Board is certified by the Massachusetts Criminal History Systems Board (CHSB) for access to conviction and pending criminal case data. As an applicant for authorization to practice as a Perfusionist, I understand that a criminal record check may be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information provided in this application pursuant to G.L. c. 112, ss. 23R through 23BB is correct to the best of my knowledge.

I agree to abide by the rules and regulations for licensing as a Perfusionist as defined in and promulgated pursuant to M.G.L. c. 13, ss. 11E.

I attest that the statements made herein are truthful and are made under the pains and penalties of perjury.

Signature of Applicant _____ **Date** _____

**Attach a recent
2x2 passport style
photo**

Notary Name: _____

Commission expires: _____

[Seal]

Attach a non-refundable fee of \$51.00 (check or Money Order) payable to the Commonwealth of Massachusetts.